HOPE CLINIC

Delivering hope and health

New and Established Patient Enrollment Checklist

All documentation must be present to enroll/ re-enroll. PREFERRED document for each section is highlighted

☐ Proof of Identification

Choose ONE bulleted item below:
PHOTO MUST MATCH PATIENT, CANNOT BE EXPIRED

- Driver's License
- Passport
- Consulate Card
- INS Document

☐ Proof of Residency

Choose ONE bulleted item below:

- Utility Bill (dated in the last 30 days and in patients name)
- Lease Contract (dated in the last year and in the patient's name)
- Mortgage Bill (dated in the last 30 days and in patient's name)
- If above items are not in patient's name:
  - Any of the above- AND-
  - ID for bill/contract addressee- AND-
  - 3 pieces of mail addressed to patient- AND-
  - Letter of Support (ask us for this form)

☐ Proof of Income

Choose ONE bulleted item below:

- Income Tax Return- most recent + signed
- Paycheck Stubs-most recent 1 month

*The following documents can be considered for proof of income, but patients providing only these documents will not be eligible for full services. Patients bringing only these documents can be seen for **Hope Clinic visits ONLY,** and are not eligible for radiology, specialty care, physical therapy, and other important resources.*

- If paid in CASH: Letter from employer on LETTERHEAD Stating ALL the following
  - Your name
  - Confirmation that you are paid in cash
  - Dollar amount of $ Income per week
  - Number of hours per week
- No Income Declaration Form (ask us for this form)

☐Other Required Documents

Bring ALL that are applicable

·Proof of Child Support · SNAP ·TANF · Public Housing

☐ Completed Registration Packet

Welcome to Hope Clinic!

Hope Clinic of Garland is a Christian clinic funded 100% by donations and grants. It's staffed with many volunteer healthcare providers who donate their time to serve you. As your new medical home, we look forward to working with you to provide the very best physical, mental, and spiritual care. Please read how you can partner with us.

We ask you to:

- Treat our team with courtesy and respect.
- Be honest about your health and enrollment information.
- Complete all testing and treatment recommended by your doctor, including preventative health procedures, such as pap smears and vaccines. *This gives you the best opportunity for good health.*
- Arrive 15 minutes before your appointment time.
- Bring ALL of your medication bottles to EVERY appointment.
- Call the clinic at least 24 hours in advance if you cannot make your appointment. This will allow another patient to be seen. *If you miss 3 appointments without calling us, you may be dismissed from the clinic.*
- These same expectations apply to any appointment for a specialist or X-ray to which we refer you. *Treat them with courtesy, show up early to your appointments, and call if you will not be able to keep your appointment.*
- Inform us of any changes to your contact information, including your name, address, phone number, or insurance status, within 30 days.
- Enroll in MyBSWHealth app so we can confidentially share your health information with you.
- Call the clinic or message through the MyBSWHealth app with any problems, questions, or medication needs. Call early in the day, so we can try to address the concern on the same day. Call back if you have not heard from us within 24 hours. For medication refills, please contact your pharmacy.
- When able, please consider supporting Hope Clinic with a donation, so we can continue to serve our community.

We promise to:

- Treat you with courtesy and compassion.
- Respect your privacy.
- Care for you to the best of our ability.
- Explain diseases, treatments, and results in an easy-to-understand way.
- Listen to you and help you make decisions about your care.
- Respond to your phone call within 24 hours.
- Provide affordable medications when possible.
- Strive to be on time for appointments.
- Pray for and with you.

_____ _____ _____

Patient signature Date of birth Today's date

Patient Information and History

Name: _____ **Date:** _____

Address: _____ **Zip Code:** _____

Phone: _____ **Email Address:** _____

Date of Birth __ / ____ / _____ **SSN** _____/ _____ / _____

Gender Preference: Male ____ Female _____ Other_____

Marital Status: Married _____ Separated _____ Divorced _____ Single _____ Widowed _____

Race: Hispanic _____ African American _____ Caucasian _____ Asian/Pacific _____ Other: _____

Preferred Language: English _____ Spanish _____ Other _____

Assistance: Do you have medical insurance? □ Yes □ No

I am enrolled in: □ Insurance through my employment: □ Medicaid □ Medicare Part A □ Medicare Part B □ Medicare Part C □ Healthy Texas Women's Program □ Affordable Care Act/Obamacare plan □ Other: _____

Additional Assistance I receive: □ Social Security Disability □ Social Security Income □ SNAP (Supplemental Nutrition Assistance Program) □ Housing □TANF □Child Support

Parkland Health Care History: When was the last time you were seen at a Parkland Health Facility (any Parkland clinic, ER, hospital?) Approx Month/year: _____Current Parkland Health Plus coverage? (Y/N) _____

Which best described your current employment status?

Employed_____ Unemployed _____ Self-Employed _____ Retired_____ Disabled _____ Other _____
Employer Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____ Telephone Number: _____

Who referred you to Hope Clinic? (Name of hospital, individual, etc.) _____

Patient Communication Preferences

Patient Name: _____ DOB: _____

As our patient, we need to communicate with you regarding appointments, medications, results, and more. You may update this information in writing at any time. Please indicate your communication preferences below:

I GIVE PERMISSION TO BE CONTACTED IN THE FOLLOWING MANNER:

- ❑ Cell phone: _____
  - Ok to leave message with detailed information
  - Leave message with call back number only
- ❑ Other number: _____
  - Ok to leave message with detailed information
  - Leave message with call back number only
- ❑ Written communication:
  - Please send all mail to my home address on file
- ❑ Text:
  - Ok to text appointment reminders, re-enrollment reminders, clinic updates (such as closings, food distribution, etc.), and other short notices to above cell phone

❑ **I GIVE PERMISSION FOR HOPE CLINIC STAFF TO CONTACT AND RELEASE MY MEDICAL INFORMATION TO:**

Name	Relationship	Phone Number

*__**Important**__: *Our physicians must be able to contact you. Please provide at least 2 trusted contacts that we can reach out to for emergencies or when we are unable to reach you. Make sure your voicemail is set up to receive messages and is not full.*

❑ **DO NOT RELEASE ANY MEDICAL INFORMATION TO ANYONE OTHER THAN ME.**

Hope Clinic respects your right to privacy and will follow the HIPAA guidelines when protecting your health information. I understand that email and standard text messages are not confidential ways of communicating and may not be secure. There may also be fees associated with these methods of communication for which our clinic is not responsible. I understand the MyBSW app is the most secure way to communicate with the clinic.

_____ _____

Patient Signature Date

Patient Consents and Notices

1. **General Consent** I consent to allow Hope Clinic of Garland to provide me with necessary medical service, evaluation, diagnosis, treatment, and care (collectively, "care"). My consent includes any examination, imaging, laboratory tests (including, but not limited to, HIV tests), medications, medical treatment, and/or other services rendered by physicians, advanced practice professionals, technical assistants, their associates, and other healthcare providers including nurses and other Hope Clinic staff (collectively, "providers"), which are advisable during the course of my evaluation, diagnosis, care, and treatment. This consent is continuing in nature during the entire course of my care, unless specifically revoked by me.

2. **Telemedicine** I consent to care through telemedicine or through the use of electronic communications such as video or virtual communications, with providers who are located at a different site.

3. **Control Over Decisions** I agree and understand that I have the right to make decisions about my care and that my providers and I will discuss and agree upon my care.

4. **Testing After Accidental Exposure** I agree and understand that Texas law provides, if any provider or healthcare worker is exposed to a patient's blood or other bodily fluid, Hope Clinic may perform test(s) on the patient's blood or other bodily fluid to determine the presence of any communicable disease. I consent to the testing for communicable diseases, in the event of an accidental exposure to a provider, healthcare worker, or other individual.

5. **State Reporting Requirements** I agree and understand that Hope Clinic of Garland or provider is required by law to report certain infectious diseases, such as HIV and tuberculosis, to the state health department or the Centers for Disease Control and Prevention. Also, I understand that Hope Clinic is required by law to report certain activities including abuse and neglect.

6. **Release of Information** I agree and understand that Hope Clinic of Garland may release my healthcare information for any purpose permitted by law and may release my information to other providers for my continued care.

7. **Communication** I authorize Hope Clinic of Garland and providers to contact me on my cell phone and/or home phone or by email, text messaging, or by any other form of electronic communication.

8. **Retention of Records** I agree and understand that Hope Clinic of Garland will retain my medical records for the required retention period. I acknowledge that Hope Clinic may authorize the disposal of medical records at the end of this retention period.

9. **Notice of Privacy Practices** I acknowledge that I have been given the opportunity to read a copy of Hope Clinic of Garland's "Notice of Privacy Practices." I acknowledge that I can obtain an additional copy of the "Notice of Privacy Practices" on our clinic's website.

10. **Photography** I consent to the photographing of myself and/or portion(s) of my body involved in my care for the purpose of my medical care.

11. **Warranty and Guarantee** I agree and understand that the practice of medicine is not an exact science and acknowledge that no warranties or guarantees have been made about the results of my care rendered by Hope Clinic of Garland or providers.

12. **Notice of Limited Liability** This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner, board member, office, employee, or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners, board member, officer, employee, or independent contractor who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. 233(a), (0)). The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic healthcare professionals providing health care services to patients at this free clinic.

_____	_____	_____
Patient Signature	Date of Birth	Today's Date

Community Referral Form

Name: _____ Date of Birth: ____ / _____ / _____

Zip Code: _____

We would like to know if there are any other difficulties, aside from your medical needs, that you or your family is currently experiencing.

Would you like information about any of the following?

1. Anxiety/Depression/Stress Yes_____ No_____
2. Food Pantry/Food Stamps Yes _____ No_____
3. Financial Assistance/Rent/Utilities Yes_____ No_____
4. Housing /Clothing Yes_____ No_____
5. Immigration/Legal Yes_____ No_____
6. Job Training/Education/GED Yes_____ No_____
7. Parenting Yes_____ No_____
8. Recent death/Loss/Grief Yes_____ No_____
9. Smoking/Drugs/Alcohol Yes_____ No_____
10. Violence/Abuse Yes_____ No_____

***** If you are having thoughts of wanting to die, hurt yourself or others or if you are in a situation where you have been or might be physically hurt, please call 911 for help. *****

Any information you provide is confidential and will only be shared with the pertinent organization.

Patient Signature: _____ Date: _____

Income Verification Form

Name: _____ D.O.B _____ / _____ / _____

Address: _____ City: _____State: ____ Zip code: _____

List all persons in household, including patient

NAME AND LAST NAME	RELATIONSHIP	AGE	OFFICE USE ONLY Documented Income	OFFICE USE ONLY Annual Income
1.	Patient			
2.				
3.				
4.				
5.				
6.				
				TOTAL

To calculate total projected annual Gross income: weekly x 52; bi-monthly x 26, monthly x 12

(If income varies, please use average)

Race: (choose one)

Caucasian____ Black or Afro-American _____ Asian_____
American Indian of Alaska Native _____ Hawaiian or another Pacific Island_____
Multi-Racial _____ Other _____

Ethnicity: Hispanic or Latino_____ Non-Hispanic or Latino_____

_____

Office Use Only
Federal Poverty Level (200%)

Circle which income category the house size reflects: EXT. LOW VERY LOW LOW

Income Verification Date: _____ Intake Person: _____ Council District: _____